Amendment No. 1 to SB0425

Watson
Signature of Sponsor

AMEND Senate Bill No. 425* House Bill No. 1379

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56; Chapter 7, is amended by adding the following as a new part:

56-7-3501. Short title.

This part is known and may be cited as the "Tennessee Pro-Family Building Act."

56-7-3502. Part definitions.

As used in this part:

(1) "Commissioner" means the commissioner of commerce and insurance;

(2) "Diagnosis of infertility" means the services, procedures, testing, or medications recommended by a licensed physician that are consistent with established, published, or approved medical practices or professional standards or guidelines from the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology for diagnosing and treating infertility;

(3) "Fertility treatment" means healthcare services, procedures, testing, medications, treatments, and/or products, including genetic testing and assisted reproductive technologies such as oocyte retrievals, in vitro fertilization, and fresh and frozen embryo transfers, provided with the intent to achieve a pregnancy that results in a live birth with healthy outcomes;

(4) "Health carrier" means an entity subject to the insurance laws this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to

provide, deliver, arrange for, pay for, or reimburse the costs of healthcare services, including an insurance company, a health maintenance organization, a health service corporation, or another entity providing a plan of health insurance, health benefits, or health services;

(5) "Infertility" means a disease or condition characterized by:

(A) The failure to conceive a pregnancy or to carry a pregnancy to live birth;

(B) A person's inability to cause pregnancy and live birth either as an individual or with the person's partner; or

(C) A licensed physician's findings and statement based on a patient's medical history, sexual and reproductive history, age, physical findings, or diagnostic testing;

(6) "Medically necessary" means healthcare services or products that are provided in a manner that is:

(A) Consistent with the findings and recommendations of a licensed physician, based on a patient's medical history, sexual and reproductive history, age, partner, physical findings, and/or diagnostic testing;

(B) Consistent with generally accepted standards of medical practice as set forth by a professional medical organization with a specialization in an aspect of reproductive health, including, but not limited to, the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists; or

(C) Clinically appropriate in terms of type, frequency, extent, site, and duration;

(7) "Monitoring" includes ultrasounds, laboratory testing, and other diagnostic tests;

(8) "Standard fertility preservation services" means services, procedures, testing, medications, treatments, and products that are consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for a person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility; and

(9) "Third-party reproductive care for the benefit of the enrollee" means the use of eggs, sperm, or embryos that are donated to the enrollee or partner by a donor, or the use of a gestational carrier, to achieve a live birth with healthy outcomes.

56-7-3503. Diagnosis of infertility, fertility treatment, and fertility preservation.

(a) On or after January 1, 2023, a health carrier that issues or renews a health insurance policy, plan, or contract of accident or health insurance providing benefits for medical or hospital expenses, shall provide coverage for the expenses of the diagnosis of infertility, fertility treatment, and standard fertility preservation services.

(b) Coverage must include:

(1) Three (3) completed cycles of intrauterine insemination, in accordance with the standards and guidelines of the American Society for Reproductive Medicine, when recommended by a physician as medically necessary;

(2) Fertility treatment and standard fertility preservation services, necessary to achieve two (2) live births, or a maximum of four (4) completed egg retrievals with unlimited fresh and frozen embryo transfers, in accordance with the guidelines of the American Society for Reproductive Medicine, and using no more than two (2) embryos per transfer, when recommended by a physician as medically necessary;

(3) Diagnosis of infertility, fertility treatment, and standard fertility preservation services, including third-party reproductive care for the benefit of the enrollee or partner;

(4) Fertility treatment consisting of a method of causing pregnancy other than sexual intercourse that is provided with the intent to create a legal parent-child relationship between the enrollee and the resulting child;

(5) Standard fertility preservation services, including the procurement, cryopreservation, and storage of gametes, embryos, or other reproductive tissue, and standard fertility preservation services when the enrollee has a diagnosed medical condition, or genetic condition, that may directly or indirectly cause impairment of fertility now or in the future by affecting reproductive organs or processes. For the purposes of this subdivision (5), "may directly or indirectly cause" means that the disease itself, or the necessary treatment, has a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology; and

(6) Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual's religious or ethical beliefs.

(c) This section shall not be construed to deny the included coverage in this section to any enrollee who foregoes a particular fertility treatment or standard fertility preservation service if the enrollee's physician determines that such fertility treatment or standard fertility preservation service is likely to be unsuccessful.

56-7-3504. Prohibited and permissible limitations on coverage.

(a) The diagnosis of infertility, fertility treatment, and standard fertility preservation services covered by the health carrier must be performed at facilities that conform to the standards and guidelines developed by the American Society for

Reproductive Medicine, the American College of Obstetricians and Gynecologists, the American Society of Clinical Oncology, or other reputable professional medical organizations.

(b) A health carrier shall make coverage for the diagnosis of infertility, fertility treatment, and standard fertility preservation services available to all individuals, including, but not limited to, those who enter coverage during special enrollment or open enrollment periods.

(c) Coverage for the diagnosis of infertility, fertility treatment, and standard fertility preservation services shall be in accordance with the standards or guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology, when recommended by a physician as medically necessary. Making, issuing, circulating, or causing to be made, issued, or circulated, clinical guidelines that are based upon data that are not reasonably current or do not cite with specificity shall constitute unfair and deceptive act and practice in the business of insurance, subject to the Tennessee Consumer Protection Act of 1977, compiled in title 47, chapter 18.

(d) Coverage for fertility treatment and fertility preservation services is limited to persons who are forty-four (44) years of age or less;

(e) This section's coverage requirements do not apply to:

(1) The TennCare program or any successor program; and

(2) A managed care organization's TennCare health plan.

(f) A health carrier shall not limit benefits under this section based upon:

(1) Co-payments, deductibles, coinsurances, benefit maximums, waiting periods, or other limitations on coverage that are different than maternity benefits provided by the health carrier;

(2) Exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications by the health carrier;

(3) A requirement that provides different benefits to, or imposes different requirements upon, a class protected under title 4, chapter 21, than that provided to or required of other patients; or

(4) A pre-existing condition exclusion, pre-existing condition waiting periods on coverage for required benefits, or prior diagnosis of infertility, fertility treatment, or standard fertility preservation services.

SECTION 2. Tennessee Code Annotated, Section 47-18-104(b), is amended by adding the following as a new subdivision:

(53) Violating § 56-7-3504(c).

SECTION 3. For the purpose of promulgating rules, this act takes effect upon becoming a law, the public welfare requiring it. For all other purposes, this act takes effect January 1, 2023, the public welfare requiring it, and applies to plans entered into, issued, amended, or renewed on or after that date.